TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS IMPAIRMENT EXAM

MFDR Tracking Number
M4-17-1651-01

MFDR Date Received
February 1, 2017

Respondent Name
ACE AMERICAN INSURANCE COMPANY

Carrier's Austin Representative
Box Number 15

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 02/26/2016 I performed an evaluation to determine maximum medical improvement and impairment of the above named claimant. I performed this examination at the request of the injured employee and the treating doctor."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS stands on the original denial of this bill for reason code 'entitlement to benefits' because this case has been adjudicated for compensability and the Decision & Order upheld that the claimant did not sustain a compensable injury. Attached is the Decision & Order and the original EOR."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
February 26, 2016	99456-NM	$350.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets out the procedure for dispute resolution.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 4 – Entitlement to benefits
   - 2 – This procedure on this date was previously reviewed

Issues

1. Have the relevant compensability issues been resolved?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for a treating doctor ordered examination, CPT Code 99456-NM rendered on February 26, 2016. The insurance carrier denied reimbursement of the disputed service with denial reason "entitlement to benefits."

   28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury.

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

   The services in dispute were denied due to "Entitlement to Benefits." The insurance carrier states in relevant part, "...this case has been adjudicated for compensability and the Decision & Order upheld that the claimant did not sustain a compensable injury." The issues raised and relevant to the services in this medical fee dispute involved whether the injured employee sustained a compensable injury. A contested case hearing (CCH) was held and a decision was issued on July 15, 2016. The division concluded the following "Claimant did not sustain a compensable injury on [date of injury]. Because Claimant did not sustain a compensable injury, he did not have disability. Carrier is not liable for benefits, and it is so ordered." The requestor's disputed service was provided for the date of injury indicated in the CCH. The division finds that the relevant issue was resolved on July 15, 2016 and found that the injured employee did not sustain a compensable injury on [date of injury].

2. Review of the submitted documentation indicates that the requestor treated the injured employee for a date of injury that was found to be non-compensable according to the CCH decision issued on July 15, 2016. For that reason, no reimbursement can be recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 16, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.